		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0020495

Facility Name: Brother James Court

Address: 2508 St. James Road (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: (217) 544-4876 **Fax #** (217) 544-4877

IDPA ID Number: 43/1588535004

Date of Initial License for Current Owners: October 1, 1975

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501(c)(3)		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Daniel J. Call **Telephone Number:** (217) 793-3363

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/03 to 6/30/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Brother David Sarnecki
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Daniel J. Call, CPA, Partner
(Firm Name & Address) Sikich Gardner & Co, LLP
1000 Churchill Road, Springfield, IL 62707
(Telephone) (217) 793-3363 Fax # (217) 793-3016

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	93	Intermediate/DD	93	34,038	4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	93	TOTALS	93	34,038	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	32,034	1,098		33,132	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	32,034	1,098		33,132	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.34%

D. How many bed-hold days during this year were paid by Public Aid?
1,508 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/01/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	280,490	31,547	1,173	313,210		313,210		313,210			1
2	Food Purchase		146,354		146,354		146,354		146,354			2
3	Housekeeping	57,283	14,672	4,388	76,343		76,343		76,343			3
4	Laundry	55,402	4,484		59,886		59,886		59,886			4
5	Heat and Other Utilities			137,523	137,523		137,523		137,523			5
6	Maintenance	82,993		81,207	164,200		164,200		164,200			6
7	Other (specify):*											7
8	**TOTAL General Services**	476,168	197,057	224,291	897,516		897,516		897,516			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,283,167	46,183	4,100	1,333,450		1,333,450		1,333,450			10
10a	Therapy			1,014	1,014		1,014		1,014			10a
11	Activities	4,688			4,688		4,688		4,688			11
12	Social Services	150,397		16,263	166,660		166,660		166,660			12
13	Nurse Aide Training			32,595	32,595		32,595		32,595			13
14	Program Transportation			12,610	12,610		12,610		12,610			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,438,252	46,183	68,982	1,553,417		1,553,417		1,553,417			16
	C. General Administration											
17	Administrative	57,996		612	58,608		58,608		58,608			17
18	Directors Fees											18
19	Professional Services			53,852	53,852		53,852		53,852			19
20	Dues, Fees, Subscriptions & Promotions			5,553	5,553		5,553		5,553			20
21	Clerical & General Office Expenses	134,828	47,850	46,037	228,715		228,715	(18,999)	209,716			21
22	Employee Benefits & Payroll Taxes			398,442	398,442		398,442		398,442			22
23	Inservice Training & Education											23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			72,686	72,686		72,686		72,686			26
27	Other (specify):*											27
28	**TOTAL General Administration**	192,824	47,850	577,182	817,856		817,856	(18,999)	798,857			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,107,244	291,090	870,455	3,268,789		3,268,789	(18,999)	3,249,790			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Brother James Court #0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			182,150	182,150		182,150	182,150	364,300			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			270,000	270,000		270,000	(270,000)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			452,150	452,150		452,150	(87,850)	364,300			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			208,504	208,504		208,504		208,504			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			208,504	208,504		208,504		208,504			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,107,244	291,090	1,531,109	3,929,443		3,929,443	(106,849)	3,822,594			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(18,999)	21		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (18,999)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,850)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (87,850)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (106,849)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ NONE		47

Brother James Court

ID# 0020495

Report Period Beginning: 07/01/03

Ending: 6/30/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/03 **Ending:** 6/30/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(18,999)	0	0	0	0	0	0	0	0	0	0	(18,999)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(18,999)	0	0	0	0	0	0	0	0	0	0	(18,999)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,999)	0	0	0	0	0	0	0	0	0	0	(18,999)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Brother James Court** **#** **0020495** **Report Period Beginning:** **07/01/03** **Ending:** **6/30/04**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	182,150	0	0	0	0	0	0	0	0	0	182,150	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(270,000)	0	0	0	0	0	0	0	0	0	(270,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	(87,850)	0	0	0	0	0	0	0	0	0	(87,850)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(18,999)	(87,850)	0	0	0	0	0	0	0	0	0	(106,849)	45

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
N/A	N/A	N/A		Franciscan Brothers of the Holy Cross	Springfield	Religious Order
				Springfield Developmental Center	Springfield	Day Training Prog.
				Weber Care Corp	Springfield	Community Living Facility

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Facility Rent	$ 270,000	Franciscan Brothers of the Holy Cross	100.00%	$	$ (270,000)	1
2	V	30	Depreciation		Franciscan Brothers of the Holy Cross	100.00%	182,150	182,150	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 270,000			$ 182,150	$ * (87,850)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Brother Raphael Kreikemeier	Food Service Supervisor	Head Cook	none	none	60	100.00	Salary	$ 50,004	1.1	1
2											2
3	Brother Luke Morin	Resident Services Coordinator	Coordinates Resident Services	none	none	60	100.00	Salary	50,004	10.1	3
4											4
5	Brother Gerald Voycheck	Social Services Director	Social Worker	none	none	60	100.00	Salary	53,004	12.1	5
6											6
7	Brother David Sarnecki	Administrator	Administrator	none	none	60	100.00	Salary	57,996	17.1	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 211,008		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Brother James Court COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0020495

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 47,210 B. General Construction Type: Exterior Brick/Stone Frame Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ Not Available	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	93		1975	1975	$ 1,003,250	$	30	$ 33,442	$ 33,442	$ 995,534	4
5			1996	1996	1,251,493		30	41,716	41,716	333,731	5
6			1997	1997	1,256,490		30	41,883	41,883	276,888	6
7											7
8											8
	Improvement Type**										
9	New Wing - Heating and air conditioning			1997	18,883		30	629	629	4,458	9
10	Repave parking lot			1986	42,236		10			42,236	10
11	Painting/decorating			1979	2,591		5			2,591	11
12	BJC - building improvements			1980	16,233		11			16,233	12
13	BJC - building improvements			1984	21,419		10			21,419	13
14	BJC - remodeling			1987	69,555		10			69,555	14
15	BJC - water line			1987	14,120		20	706	706	11,296	15
16	Insulation			1991	9,175		15	612	612	7,901	16
17	Electrical repair			1991	613		10			613	17
18	Boiler tank removal			1992	15,089		20	755	755	9,214	18
19	Tank removal			1992	8,500		10			8,500	19
20	Dishwashing room server			1992	10,680		20	534	534	6,675	20
21	BJC - steam line			1985	14,479		10			14,479	21
22	BJC - building improvements			1975	19,600		24			19,600	22
23	BJC - Dining area remodeling			1976	34,951		10			34,951	23
24	BJC - sidewalk/patio			1976	3,545		10			3,545	24
25	BJC - Bike rink			1978	2,500		5			2,500	25
26	BJC - Air conditioning system			1979	22,876		10			22,876	26
27	BJC - site improvement			1979	1,440		26	55	55	1,408	27
28	Roof			1979	12,166		10			12,166	28
29	Roofing			1986	45,811		10			45,811	29
30	Remodeling			1988	46,656		10			46,656	30
31	Water line			1989	3,166		20	158	158	2,454	31
32	Sewage treatment plant			1990	6,411		20	321	321	4,541	32
33	Tank removal			1991	9,809		10			9,809	33
34	Parking lot			1992	10,452		10			10,452	34
35	Paint restrooms			1992	230		5			230	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Boiler room remodeling	1993	$ 15,106	$	20	$ 755	$ 755	$ 8,314	37
38	Repave parking lot	1994	850		10	85	85	829	38
39	Pump	1994	734		10	73	73	745	39
40	Air conditioner work	1994	943		10	94	94	951	40
41	Boiler room project	1994	170,330		20	8,517	8,517	83,956	41
42	Land improvement - trees	1996	3,470		20	174	174	1,360	42
43	BJC - improvements	1998	15,712		30	524	524	3,317	43
44	Water line repair	1999	3,101		10	310	310	1,473	44
45	Land improvement - trees	1999	25,849		20	1,293	1,293	6,247	45
46	Gate	1999	550		5	110	110	513	46
47	Remodeling	1999	5,773		10	577	577	2,646	47
48	Floor	2000	1,683		7	240	240	1,002	48
49	Total Life Center	1998	122,261		30	4,075	4,075	24,791	49
50	Parking lot blacktop	2000	49,310		15	3,287	3,287	12,327	50
51	Leasehold improvements	1985	15,200		10			15,200	51
52	Leasehold improvements	1986	19,507		10			19,507	52
53	Painting	1987	9,922		3			9,922	53
54	Steel door	1987	6,020		10			6,020	54
55	Window replacement	1987	2,013		10			2,013	55
56	Generator switch	1988	3,335		10			3,335	56
57	Remodel lobby	1989	156,996	5,233	30	5,233		76,318	57
58	Bus hut	1989	4,715	314	15	314		4,610	58
59	Water heater	1989	6,721		10			6,721	59
60	Transfer switch	1989	1,127		10			1,127	60
61	Heat-energy panel	1989	8,633		10			8,633	61
62	Leasehold improvements	1989	6,629	77	10	77		6,590	62
63	Roof repair	1990	6,928		10			6,928	63
64	Remodeling	1990	6,953	232	30	232		3,284	64
65	Overhead door	1990	1,220		10			1,220	65
66	Kitchen tanks	1990	3,089		10			3,089	66
67	Plastering	1990	2,586		10			2,586	67
68	Remodel ceiling	1990	2,970		10			2,970	68
69	Leasehold improvements	1990	26,015		10			26,015	69
70	TOTAL (lines 4 thru 69)		$ 4,680,670	$ 5,856		$ 146,781	$ 140,925	$ 2,392,881	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,680,670	$ 5,856		$ 146,781	$ 140,925	$ 2,392,881	1
2	Leasehold improvements	1991	2,141		10			2,141	2
3	Window replacement	1992	2,750		10			2,750	3
4	Cafeteria doors	1993	11,918		10			11,918	4
5	Plumbing work	1994	6,858	686	10	686		6,858	5
6	Painting	1995	3,076	308	10	308		2,768	6
7	Wall and door repair	1995	2,596	260	10	260		2,336	7
8	Door	1996	656	66	10	66		525	8
9	Roof repair	1996	5,985	598	10	598		4,787	9
10	Painting	1996	1,620		10			1,620	10
11	Furnace	1996	502	50	10	50		401	11
12	Land improvements	1996	1,385		3			1,385	12
13	Repairs	1996	10,702	103	5	103		10,497	13
14	Grip caps	1996	1,575		5			1,575	14
15	Boiler	1996	3,335	333	10	333		2,669	15
16	Bedding	1996	1,505		3			1,505	16
17	Air deflectors	1996	381		3			381	17
18	Shower	1996	259		5			259	18
19	Sewer	1996	9,387	939	10	939		7,510	19
20	Painting	1996	4,928	493	10	493		3,943	20
21	Roof repair	1997	798	80	10	80		559	21
22	Drapes	1997	4,500		5			4,500	22
23	Floor coverings	1997	1,722	172	10	172		1,205	23
24	Drapes - Life Center	1997	3,153		5			3,153	24
25	Floor coverings - Life Center	1997	4,422	442	10	442		3,096	25
26	Painting - Life Center	1997	8,917	892	10	892		6,242	26
27	Floor	1997	2,658	158	10	158		2,186	27
28	Alarms/Smoke detectors	1998	20,108	2,314	5	2,314		20,108	28
29	Snack lounge - remodeling	1999	2,847	380	5	380		2,847	29
30	Roof repairs	1999	846	84	10	84		444	30
31	Carpet in front office	1999	8,881	1,480	5	1,480		8,881	31
32	Yard signs	1999	2,825	283	10	283		1,436	32
33	New tees & valves	1999	11,685	1,169	10	1,169		5,940	33
34	TOTAL (lines 1 thru 33)		$ 4,825,591	$ 17,146		$ 158,071	$ 140,925	$ 2,519,306	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,825,591	$ 17,146		$ 158,071	$ 140,925	$ 2,519,306	1
2	Vinyl wall covering	1999	1,127	113	10	113		564	2
3	Shower room repairs	1999	8,220	822	10	822		4,110	3
4	Connection fees for sewer project	1998	7,438	744	10	744		4,153	4
5	Tree removal	1999	9,857	985	10	985		4,764	5
6	Condenser	1999	12,396	1,239	10	1,239		5,992	6
7	Leasehold improvements	1999	2,598	520	5	520		2,511	7
8	Landscaping	1999	18,255	1,825	10	1,825		8,594	8
9	Drop rod assembly	1999	6,408	641	10	641		3,044	9
10	Fencing	1999	3,840	384	10	384		1,792	10
11	Trees	1999	9,905	991	10	991		4,540	11
12	Roof repairs	2000	2,300	230	10	230		997	12
13	Tile floor - resident wing	2000	34,740	3,474	10	3,474		15,054	13
14	Painting	2000	6,352	1,271	5	1,271		5,400	14
15	Window replacement	2000	2,009	201	10	201		854	15
16	Leasehold improvements	1999	5,754	1,152	5	1,152		5,027	16
17	Cabinet modifications	1999	4,520	646	7	646		2,906	17
18	Professional electrical services	1999	17,410	1,160	15	1,160		5,803	18
19	New sign out front	1999	900	180	5	180		900	19
20	Masonry work for BJC	1999	23,465	1,564	15	1,564		7,821	20
21	Professional plumbing and heating services	1999	31,000	2,066	15	2,066		10,333	21
22	Remodeling	1999	19,524	1,301	15	1,301		6,508	22
23	Parking lot stripes	2000	1,549	310	5	310		1,214	23
24	Painting basement ceiling	2000	664	133	5	133		465	24
25	Draperies	2001	10,881	2,176	5	2,176		6,211	25
26	Ranp area decorating	2001	14,387	2,877	5	2,877		8,392	26
27	Painting & wallcovering	2001	8,058	1,611	5	1,611		4,566	27
28	Air curtain	2001	1,812	258	7	258		733	28
29	Recepticles - Bedrooms	2001	9,820	1,964	5	1,964		5,237	29
30	Shower room floor repairs	2002	1,123	112	10	112		280	30
31	Door repairs	2002	6,197	621	10	621		1,458	31
32	Boiler repairs	2002	3,960	792	5	792		1,980	32
33	Draperies	2002	4,200	840	5	840		2,030	33
34	TOTAL (lines 1 thru 33)		$ 5,116,260	$ 50,349		$ 191,274	$ 140,925	$ 2,653,539	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,116,260	$ 50,349		$ 191,274	$ 140,925	$ 2,653,539	1
2	Architect fees - remodel bathroom area	2002	9,863	3,287	3	3,287		7,671	2
3	Repave sidewalks	2002	810	81	10	81		182	3
4	Tuckpointing	2002	1,490	149	10	149		323	4
5	Repair floors	2002	2,688	269	10	269		582	5
6	Keylock pad	2002	580	58	10	58		111	6
7	Strip & refinish floors	2002	8,702	870	10	870		1,471	7
8	Hot water storage tank	2002	4,408	441	10	441		661	8
9	Doors & frames	2003	3,733	373	10	373		466	9
10	Pole lighting - west parking lot	2004	3,740	145	15	145		145	10
11	Sink faucet & cabinet	2004	1,133	54	7	54		54	11
12	Wallpapering/painting	2004	2,358		15				12
13	Doors	2004	4,987	55	15	55		56	13
14	Ceiling fan	2004	1,082	26	7	26		26	14
15	Electric work	2004	16,000		15				15
16	Alarm system	2004	2,204		7				16
17	Boiler - kitchen steamer	2004	4,871	116	7	116		116	17
18	Boiler	2004	6,900	411	7	411		411	18
19	Boiler	2004	7,200		7				19
20	Toilet Room addition/renovation	2003	699,826	12,378	30	12,378		12,378	20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,898,835	$ 69,062		$ 209,987	$ 140,925	$ 2,678,192	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 625,466	$ 77,468	$ 77,468	$		$ 396,139	71
72	Current Year Purchases	23,386	837	837			837	72
73	Fully Depreciated Assets	983,251	20,091	20,091			983,251	73
74								74
75	TOTALS	$ 1,632,103	$ 98,396	$ 98,396	$		$ 1,380,227	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Resident	Trucks	Various	$ 72,449	$ 11,482	$ 11,482	$		$ 63,720	76
77	Transportation	Vans (& wheelchair lift)	Various	34,424	2,709	2,709			30,811	77
78		Cars	Various	41,823	500	500			40,532	78
79										79
80	TOTALS			$ 148,696	$ 14,691	$ 14,691	$		$ 135,063	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 7,679,634	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 182,149	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 323,074	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 140,925	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,193,482	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Parking lot	$ 9,010	92
93	Wing 100 Remodeling	3,443	93
94			94
95		$ 12,453	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Franciscan Brothers of the Holy Cross

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 1975
Ending 2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	6/30/2005	$ 270,000
13.	6/30/2006	$ 270,000
14.	6/30/2007	$ 270,000

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ NONE Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 40

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 85

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies			595		595
3	Classroom Wages	(a)		8,827		8,827
4	Clinical Wages	(b)		18,758		18,758
5	In-House Trainer Wages	(c)		4,415		4,415
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$ 32,595	$	$ 32,595
10	SUM OF line 9, col. 1 and 2	(e)	$ 32,595			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	24
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	24

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Brother James Court # 0020495 **Report Period Beginning:** 07/01/03 **Ending:** 6/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,043,149	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	331,733		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	22,288		6
7	Other Prepaid Expenses	6,345		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,403,515	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,396,636		12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	1,508,745		15
16	Equipment, at Historical Cost	1,780,799		16
17	Accumulated Depreciation (book methods)	(2,006,689)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Construction in progress	12,453		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,691,944	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,095,459	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 10,221	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	59,007		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued vacation	55,193		36
37	Other (miscellaneous)	216		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 124,637	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 124,637	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,970,822	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,095,459	$	48

***(See instructions.)**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 4,030,815	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 4,030,815	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(59,993)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (59,993)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,970,822	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,539,353	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,539,353	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	32,713	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	9,707	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 42,420	23
	D. Non-Operating Revenue		
24	Contributions	151,257	24
25	Interest and Other Investment Income***	60,443	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 211,700	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Fundraising	74,177	28
28a	Vehicle Rental	1,800	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 75,977	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,869,450	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	897,516	31
32	Health Care	1,553,417	32
33	General Administration	817,856	33
	B. Capital Expense		
34	Ownership	452,150	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	208,504	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,929,443	40
41	**Income before Income Taxes (line 30 minus line 40)****	(59,993)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (59,993)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,675	1,881	$ 45,287	$ 24.08	1
2	Assistant Director of Nursing					2
3	Registered Nurses	966	966	17,342	17.95	3
4	Licensed Practical Nurses	13,909	15,002	204,568	13.64	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	3,120	3,120	53,004	16.99	11
12	Dietician					12
13	Food Service Supervisor	3,120	3,120	50,004	16.03	13
14	Head Cook					14
15	Cook Helpers/Assistants	26,006	28,155	230,486	8.19	15
16	Dishwashers					16
17	Maintenance Workers	5,748	6,701	82,993	12.39	17
18	Housekeepers	5,887	6,424	57,283	8.92	18
19	Laundry	4,467	4,867	55,402	11.38	19
20	Administrator	3,120	3,120	57,996	18.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,417	9,098	134,828	14.82	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	6,671	7,560	97,393	12.88	28
29	Resident Services Coordinator	3,120	3,120	50,004	16.03	29
30	Habilitation Aides (DD Homes)	93,537	100,762	970,654	9.63	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	179,763	193,896	$ 2,107,244 *	$ 10.87	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	29	$ 1,173	1.3	35
36	Medical Director	Various	2,400	9.3	36
37	Medical Records Consultant	3	94	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Various	1,100	10.3	39
40	Physical Therapy Consultant	4	175	12.3	40
41	Occupational Therapy Consultant	1	48	12.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	59	2,350	12.3	43
44	Activity Consultant				44
45	Social Service Consultant	Various	6,490	12.3	45
46	Other(specify)				46
47	Psychologist Consultant	Various	7,200	12.3	47
48					48
49	TOTAL (lines 35 - 48)	96	$ 21,030		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brother David Sarnecki	Administrator	None	$ 57,996
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,996

B. Administrative - Other

Description	Amount
Background checks	$ 612
TOTAL (agree to Schedule V, line 17, col. 3)	$ 612
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Sikich Gardner & Co, LLP	Acctng, Audit, Technology	$ 11,710
Illinois National Bank	Administrative	8,518
Bank One	Administrative	269
Sheehan & Sheehan	Legal	305
Stratton & Giganti	Legal	32,475
Londrigan, Potter & Randle, PC	Legal	87
Kevin N. McDermott	Legal	350
Other	Administrative	138
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 53,852

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 69,300
Unemployment Compensation Insurance	19,426
FICA Taxes	136,817
Employee Health Insurance	96,956
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contribution	69,839
Life Insurance	6,104
TOTAL (agree to Schedule V, line 22, col.8)	$ 398,442

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,220
Health Care Worker Background Check	
(Indicate # of checks performed)	
Membership Dues	2,425
Subscriptions	908
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,553

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ NONE
In-State Travel	NONE
Seminar Expense	NONE
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Brother James Court # 0020495 Report Period Beginning: 07/01/03 Ending: 6/30/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-7 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,735** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **208,504**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **NONE** Has any meal income been offset against related costs? **NO** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **YES** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **9,707**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **NONE**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **Sikich Gardner & Co, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **YES** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.